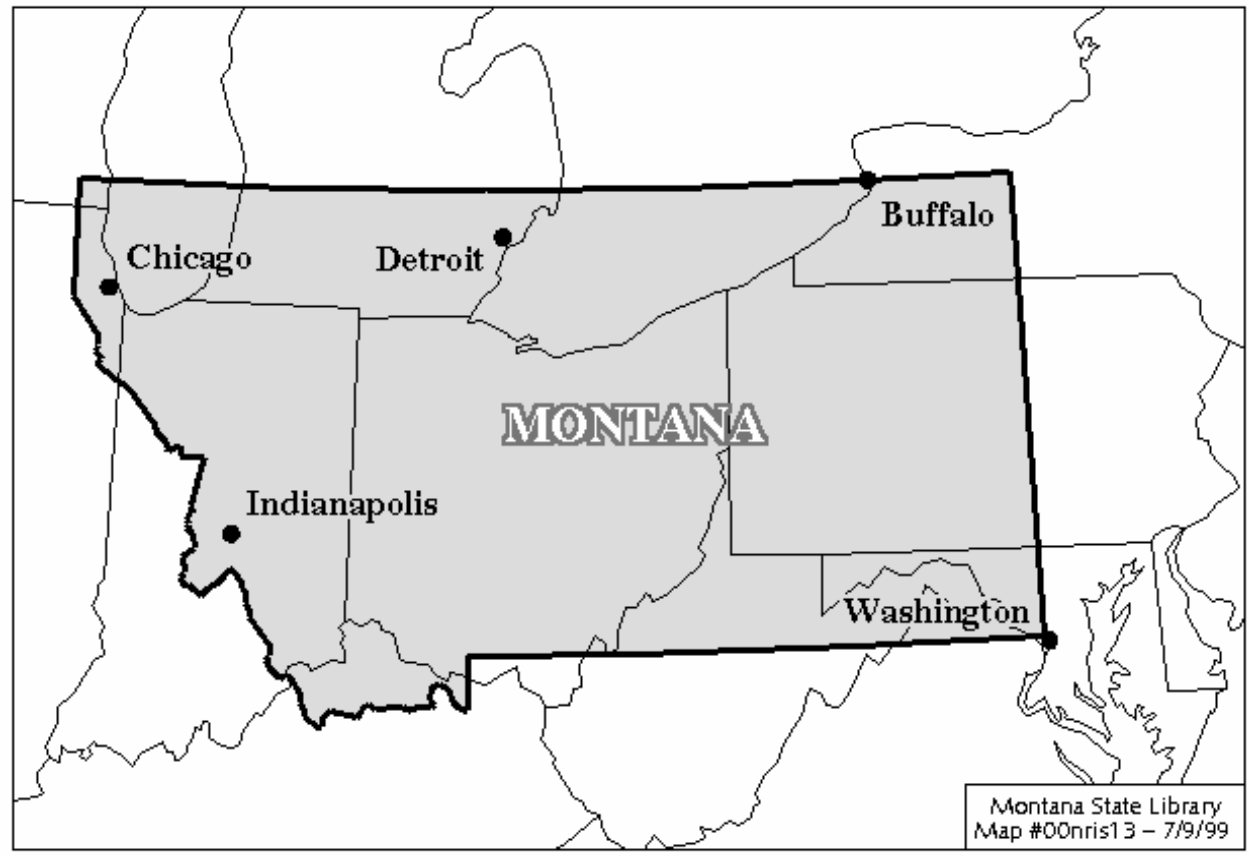
SECTION ONE
DESCRIPTION OF MENTAL HEALTH SYSTEM

Montana is known as "Big Sky Country" because of its vast size, expansive skies, and rolling plains. The state covers a landmass of 147,029 square miles, has an estimated population of 944,330 (2006), and a population density of 6.2 persons per square mile. To adequately demonstrate the size of Montana a map has been included. In 2005, Montana had one of the lowest average annual wages ($34,449) in the nation, yet ranked third in the number of people holding multiple jobs. An estimated 14% of the population lives in poverty, including over 19% of our children.



The population of Montana is predominately Caucasian (91%). The principal minority group in Montana is American Indian (6.2%). Included within the boundaries of Montana are seven Indian reservations. Each is a distinct and sovereign nation with unique cultural differences requiring individual partnerships. Poverty on the reservation is extreme, ranging from a low of 20% on the Flathead Reservation to a high of 39% at Fort Belknap. Unemployment rates range from 44% to 55%. The Indian Health Service provides behavioral and medical services for tribal members at 13 sites throughout Montana, both on the reservations and in the urban locations of Billings, Helena, Great Falls, and Butte. Other minority populations include Hispanic (2%), Asian or Pacific Islander (.6%), and African American (.3%). 28.6% of the population is under

the age of 20.

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for public mental health system. The adult and children's system have separate administrative structures within DPHHS. The adult mental health system is administered by the Addictive and Mental Disorders Division, through the Mental Health Services Bureau. This division also administers three state-run facilities: the Montana State Hospital, the Montana Mental Health Nursing Care Center, and the Montana Chemical Dependency Center. The Health Resources Division administers children's services through the Children's Mental Health Bureau. In addition, Health Resources Division is responsible for Medicaid Primary Care services, and the Children's Health Insurance Program (CHIP).

The principle challenge to developing and maintaining human services programs in Montana is accessibility. Although concentrating services in larger areas would be the most efficient strategy for delivery, Montana has maintained an effort to provide mental health services in every county in the State. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Because of the frontier nature of Montana, our entire plan is essentially a plan for delivery of mental health services in rural settings. For this reason, as will be further explained in "Descriptive Information" under ***Criterion 4,*** we have not identified specific objectives relating to rural issues. The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural areas.

Separate administration and budgets don't preclude the adult and children's mental health systems from working together, collaborating, and ensuring quality public mental health services. Staff, administrators, parents, and consumers collaborate in meetings, services, and training in efforts to provide adequate services to those in Montana with serious mental illness. At the state level, the Mental Health Oversight Advisory Council (MHOAC) has representatives from the children's mental health system, and likewise, the System of Care Committee (SOC) has representatives of the adult mental health system. At the regional and local levels the same is true.

The philosophy of the children's public mental health system is to provide services that respect the preferences and rights of youth and family members as well as accommodate the special needs and circumstances of both. Montana's public mental health system strives to provide a full range of mental health services to children and adolescents with priority on services to youth with serious emotional disturbance. To the greatest extent possible, services are offered in the least restrictive, most appropriate, culturally competent community-based setting, preferably in the adolescent or youth's home.

The Children Mental Health Bureau (CMHB) is responsible for management of children's mental health services and development of a system of care for youth mental health services. The mental health services have several funding sources: Medicaid, Children's Health Insurance

Plan (CHIP), the Children's Mental Health Service Plan (CMHSP) and a Supplemental Services Plan which used to be combine with CMHSP. Youth with serious emotional disturbance can access services by one of these plans. Each program has eligibility criteria and limits to their service array. Montana was awarded a Community Based Alternatives to Psychiatric Residential Treatment Facilities demonstration grant (part of the Deficit Reduction Act of 2005) in 2007 which will begin in the Billings area in October 2007 and will offer wrap-around services to youth as a diversion from residential placement.

During the 2005 Legislative session the Montana Legislature increased the Medicaid eligibility resource test to $15,000. In State Fiscal year 2006, CHIP made 2323 referrals to Medicaid based upon the resource increase moving from the Children's Health Insurance Program (CHIP) to Medicaid. July 1, 2007 the eligibility level was increased to 175% of poverty increasing their capacity to enroll 16,000 youth. Current enrollment is 14,382. Although CHIP remains a capped service the waiting list has been eliminated. CMHSP income guidelines have been increased to match the CHIP eligibility at 175% of poverty. One hundred thirty-five youth are eligible for CMHSP if they are not eligible for Medicaid or CHIP.

Montana currently has four community mental health centers that provide outpatient services in fifty-five of fifty-six counties. In addition, Montana has eleven licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center. The Department contracts with local agencies to provide targeted youth case management. The providers identify where their services will be offered.

The philosophy of the adult mental health system is to provide a person centered system focusing on all services provided to the individual. All services available have the goal of recovery. << add a section on recovery and transformation>>

Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee for service system that includes eight licensed mental health centers, 444 licensed clinical professional counselors (6 out of state); 207 social workers (12 out of state); 103 midlevel practitioners (2 out of state); 184 psychologists (50 out of state); 183 psychiatrists (114 out of state); The state also administers the Mental Health Services Plan (MHSP) for adults with SDMI who are not eligible for Medicaid and have a family income that does not exceed 150% of the federal poverty level. MHSP services are contracted to four community mental health centers, and beneficiaries receive a limited pharmacy benefit of $425 per month toward the cost of psychotropic medications.

Children's System of Care Committee

Legislated in 2003, the Children's System of Care Committee re-designed and more clearly defined their mission and goals in May 2007. They have separated into two committees: the statutorily mandated State Policy Team, MCA 52-203, and the Planning Committee whose primary functions will include oversight of the SAMHSA grant and to recommend policy changes to the State team. This reconstituted SOC committee(s) has energized the membership

and will expand our ability to communicate with local groups and enhance the progress towards a meaningful and sustainable system of care for youth.

Guided by the following values, this system has continued to evolve and strengthen in its capacity to manage the emerging system of care and provide leadership to local communities as Montana moves towards family and youth driven, community based mental health services:

- Parent/Family participation at all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- Cultural competence requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- A focus on the strengths of the parents and family as drivers of treatment and recovery.
- "Top-Down-Bottom Up approach" in partnerships with local communities, including our seven sovereign nations to design and develop the system of care.
- Through partnerships with providers, design and deliver evidenced-based services and promising practices to youth with SED and their families.
- Increase co-occurring capacity to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

The SOCs Statutory Planning Committee will be chaired by the Director of DPHHS or designee. The following members, required by statute, will be on the SOCs Statutory Planning Committee:

- Mental Health Representative
- Child and Family Services
- Development Disability Program Representative
- Chemical Dependency Treatment Program
- Other appointees considered appropriate by the director (Human and Community Service Division; Early Childhood Services Bureau; Family and Community Health Bureau)
- Appointee of the Superintendent of Public Instruction representing education
- Appointee of the Director of the Department of Corrections
- Appointee of the Youth Justice Council of the Board of Crime
- Appointee of the Supreme Court representing the Youth

Additional appointments may include: the Mental Health Ombudsman, attached to the Governor's Office, the Governor's Policy Advisor on Families, the Governor's Indian Affairs Coordinator, and a representative from the Crow Nation.

This group will coordinate its planning work with the Community Planning Committee and may receive from or make recommendations to the Community Planning Committee.

<u>SOCs Community Planning Committee</u>

This group will have representation from the following community stakeholders as described in the SAMSHA grant application:

- Parents, youth and family

- KMAs and local multi-agency teams on a regional basis
- Providers
- At least three (3) representatives from the SOCS Statutory Planning Committee.
- Native American representation commensurate with the percentage of Native American in Montana.

Other members of the group may include: local government representatives, local child-serving agency reps, involved community members including business owners.

The Community Planning Committee will meet four (4) times a year, including one annual meeting with the Statutory Planning Committee. Each member of this group will be appointed to either a two (2) or a four (4) year term. Children's Mental Health Bureau staff will provide support to this committee, including minutes, production of information, reports, and the identification of key issues related to the grant or to the development of the system of care.

October 2007 begins the fourth year of our six year SAMHSA grant. The first community grants were awarded in October 2005 to Billings, Missoula and the Crow Nation, our SAMHSA partner. The state has terminated its contractual relationship with the Missoula fiduciary and the local community team. Three additional communities were awarded grants in August 2006 -- Helena, Butte, and a northern Montana collaboration between the Fort Belknap Reservation, the Rocky Boy's Reservation and Hill County. All sites will be enrolling youth in the National Evaluation and providing services to youth beginning July 2007.

Kids Management Authorities

Kid's Management Authorities provide a process by which parents, youth, providers and communities can come together to create a comprehensive local system for youth with serious emotional disturbance. Stakeholders include parents, youth, and representatives from education, juvenile justice, child and family services, developmental disabilities, and service providers.

KMAs have two functions:

- **Community Teams**
  They are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure unified and comprehensive service delivery, and serve as the gateway to the local system.
- **Individual Care Coordination Teams (ICCT)**
  With few exceptions, parents are the leaders of the individual team for their child. The team, comprised of agencies and individuals involved with the youth and their family design a unified and comprehensive treatment plan that encompasses all agencies serving an individual family.

Communities have each developed their own unique way to implement the principles and spirit

of the KMA process. As intended, local culture and priorities set the stage for the KMA in each community.

Mental Health Oversight Advisory Council

The Mental Health Oversight Advisory Council (MHOAC) provides valuable input to the Department. The mission of the Council is ". . . Partners in planning for recovery based mental health system throughout Montana." The purpose of the Council as defined in state law (53-21-701(6) (a-d) is to:

- Provide input to the department in the development and management of any public mental health system.
- Provide a summary of each meeting and a copy of any recommendations made to the Department to the Legislative Finance committee and any other designated appropriate legislative interim committee.
- Fulfill any federal advisory council requirements in order to obtain federal funds for this program.

In addition, the Mental Health Oversight Advisory Committee has established the following guiding principles:

- Recovery and resilience
- Equity, access and satisfaction
- Cultural competence
- Community-based solutions
- Community education and awareness
- Flexibility
- Criminal Justice diversion
- Address co-occurring disorders
- Fiscal responsibility

In February 2007 the Mental Health Oversight Advisory Council with additional participants engaged in what was called "Two Worlds; One Journey". This visioning process was designed to look at mental health services over the lifespan, from the perspective of a family affected by mental illness. Three work groups- children, adult and crisis- developed a set of guiding statements; those were then reviewed by the larger group. Two primary themes emerged- prevention and early intervention at all levels of the system, and reduction of stigma. <<more ??>>

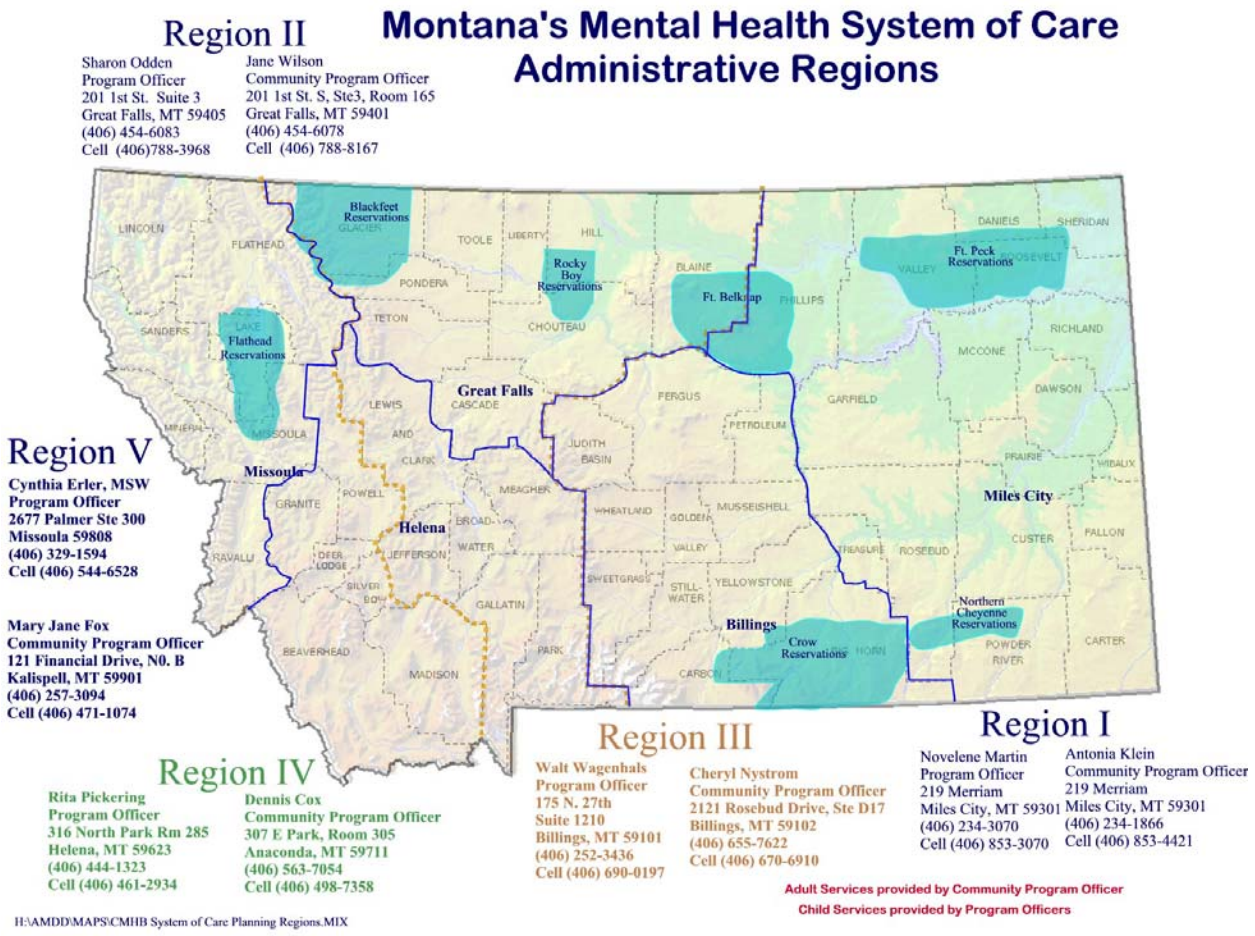
Service Area Authorities <<and Local Advisory Councils????>>
<<UPDATE THIS>>

Service Area Authorities are intended to exercise local control of the public mental health system by stakeholders. Emphasis is placed on achieving better consumer outcomes, increased performance by service providers, and more cost-effective service delivery. By dividing the state

into three separate regions, communities within each region can better manage a system that meets the unique needs of the area.

Restructuring the public mental health system in Montana has been no small task. Each SAA has obtained nonprofit corporation status and has a leadership board. The board has 51% consumer and family member representation. The SAA and LAC development has taken over five years. The Department is requesting the SAA and LAC to actively participate in the development of the crisis response plan for Montana.

What follows is the map of the administrative regions and the program officers for the children's mental health and adult mental health systems.



New Initiatives

The 2007 Montana Legislature authorized what's known as House Bill 98. This legislation creates a repository for Medicaid general fund match dollars and as well as other funds to be used as a means to provide non-Medicaid funded services to youth and their families. The vision

is to create opportunities for success by offering services to support youth and their families prior to placement in a higher level of care or as a part of a step-down plan back into community. We hope to implement this by fall 2007.

Another very exciting new program is the Community-Based Alternative to Psychiatric Residential Treatment Facilities (PRTF). Montana was chosen as one of ten states to receive this five-year demonstration grant which allows Medicaid dollars to be used to divert youth from residential care. Montana will use wrap-around services as our primary strategy for support and services.

Children's Mental Health Bureau, in conjunction with the Montana Mental Health Association launched a state-wide media campaign on youth and mental illness. The messages, delivered by real Montanans about their emotional and family struggles, attempt to reduce stigma by putting a face to the issue and hope for their futures. 1136 thirty seconds television spots were aired in seven communities across Montana. Fifty radio stations in fourteen Montana communities and one western North Dakota community aired 4014 thirty second radio spots. This represents the first six month of a year long campaign.

Targeted youth case management is under-going a significant revision in how the state administers the service. Sixty units (15 hours) of targeted case management will be allowed. Then a prior authorization for additional services will be required and will include a review of the seriously emotionally disturbance criteria to ensure youth meet the medical necessity and diagnostic criteria for ongoing services.

In an effort to support prevention and early intervention, youth without an SED diagnosis will be allowed up to twenty-four (24) outpatient individual and family therapy and unlimited group therapy sessions per fiscal year.

An initiative to strengthen CMHB's relationship with each one of the seven sovereign Native American nations will be designed and implemented in this next year. The current plan is in the very early stages of development.

<<Adult Initiatives go here>>

The major initiatives for the MHSB are: designing a crisis response system; the SSI/SSDI outreach, access, and recovery (SOAR) training; co-occurring initiative; strengths based case management; housing projects; shelter plus care vouchers; Dialectical Behavioral Therapy (DBT) and Assertive Community Teams (ACT) are stronger and more effective; pursuing a Health Insurance Flexibility and Accountability (HIFA) and Home and Community Based Waivers; strengthening the relationship with the SAAs and the division; developing peer support services; and utilizing the field staff.